TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Russell Juno, M.D.

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-15-3551-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 25, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "There is a $150.00 balance on this claim…"

Amount in Dispute: $750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Additional reimbursement has already been issued in the amount of $600.00 due to non-musculoskeletal body areas that were rated. Please note the following regarding the three (3) musculoskeletal body areas.

Per 28 TAC 134.204 there are three musculoskeletal body areas billable for impairment rating. The lower extremities are considered one body area."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 17, 2015	Examination to Determine MMI/IR	$750.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of medical bills.
3. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 45 – Not defined as required in 28 Texas Administrative Code §133.240.

- Z710 – The charge for this procedure exceeds the fee schedule allowance.
- P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Additional payment made on appeal/reconsideration.

Issues

1. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. While the requestor included CPT Codes 99456-MI and 99456-W6-RE on the Medical Fee Dispute Resolution Request (DWC060), they are seeking $0.00 for these services. Therefore, these codes will not be considered.

   Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is $350.00.

   This dispute involves a Designated Doctor Impairment Rating (IR) evaluation, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4), which states that:

   (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
   (i) Musculoskeletal body areas are defined as follows:
   (I) spine and pelvis;
   (II) upper extremities and hands; and,
   (III) lower extremities (including feet).
   (ii) The MAR for musculoskeletal body areas shall be as follows…
   (II) If full physical evaluation, with range of motion, is performed:
   (-a-) $300 for the first musculoskeletal body area; and
   (-b-) $150 for each additional musculoskeletal body area.
   (D) …
   (i) Non-musculoskeletal body areas are defined as follows:
   (I) body systems;
   (II) body structures (including skin); and,
   (III) mental and behavioral disorders.
   (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides…
   (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150.

   Review of the submitted documentation finds that the requestor performed impairment rating evaluations of the lumbar spine, lower extremities (including right knee, ankle, and hindfoot; and left knee, ankle, and hindfoot), hearing, nervous system (including headache and "neurological"), and mental/behavioral disorder (PTSD). Therefore, the total MAR for the examination to determine impairment rating is $900.00.

   Please see the table below for analysis.

Examination	AMA Chapter	§134.204 Category	MAR
Maximum Medical Improvement	[redacted]		$350.00
IR: Lumbar Spine (ROM)	Musculoskeletal System	Spine/Pelvis	$300.00
IR: Right Knee (ROM)		Lower Extremities	$150.00
IR: Right Ankle (ROM)			
IR: Right Hindfoot			
IR: Right Knee (ROM)			
IR: Left Ankle (ROM)			
IR: Left Hindfoot			
IR: Hearing Loss	ENT & Related Structures	Body Structures	$150.00
IR: Headache (Brain)	Nervous System	Body Systems	$150.00
IR: Neurological			
IR: PTSD	Mental & Behavioral	Mental & Behavioral	$150.00
Total MMI	[redacted]		**$350.00**
Total IR			**$900.00**
Total Exam			**$1,250.00**

2. The total MAR for the disputed services is $1250.00. The insurance carrier paid a total of $1550.00. No further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	August 31, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.